GARY A. MATUSOW, D.O.
Board Certified Gastroenterologist

VINCE MCLAUGHLIN, M.D.
Board Certified Gastroenterologist

MARIA PAGAN, MSN, APNC
Board Certified Advanced Practice Nurse

Dear Patient,

Thank you for choosing The Gastroenterology Group and Endoscopy Center of South Jersey for your medical care. Our address is 602 W. Sherman Ave.

We respectfully ask that you complete the attached paperwork, both front and back sides, and either mail it back to our office at the address below or, **bring it along with you the day of your visit**.

In addition, please bring:

- **Your current insurance cards**
- **Referrals with ALL the correct, understandable information, i.e. date of birth, date of referral, name of patient, insurance identification number specialist name and provider number**
- **Any lab work or medical records you may have**
- **Your co-pay**

If, for any reason you are unable to make your appointment, do not have **ALL** the information noted above or, if you are scheduled for a procedure and have questions regarding the preparation you need to take, please contact our office **24** to **48** hours prior to your appointment at 856.691.1400.

Thank you and we look forward to greeting you the day of your appointment.

Sincerely,

The Staff of GGSJ and ECSJ

Enclosures

602 W. Sherman Avenue Vineland, NJ 08360-7072 Phone 856.691.1400 Fax 856.691.7117 www.gastrogroupsj.com

DEMOGRAPHICS

LAST NAME ________________________FIRST NAME_______________________MIDDLE INITIAL_____

STREET______________________________CITY___________________STATE_______ZIP___________

HOME PHONE________________WORK PHONE__________________CELL PHONE_______________

SEX M____ F____ EMAIL__________________ALTERNATIVE CONTACT NUMBER________________

AGE_________DATE OF BIRTH____/____/____SOCIAL SECURITY #____________________________

PARENT NAME (IF MINOR)___________________________MARITAL STATUS____________________

PLACE OF EMPLOYMENT AND PHONE #____

REFERRING PHYSICIAN'S NAME AND #____

PHARMACY NAME AND #____

INSURANCE INFORMATION

NAME OF INSURANCE COMPANY____

POLICY #_______________________________________GROUP #_______________________________

SUBSCRIBERS NAME____

OTHER INSURANCE____

PLEASE LIST ANY OTHER PRESCRIPTION DRUG COVERAGE (IF OTHER THAN YOUR MEDICAL PLAN) ____

I CERTIFY THAT THE ABOVE INFORMATION IS CORRECT TO THE BEST OF MY KNOWLEDGE. I WILL NOT HOLD MY DOCTOR OR ANY OTHER MEMBERS OF HIS STAFF RESPONSIBLE FOR ANY ERRORS OR EMISSIONS THAT I MAY HAVE MADE IN THE COMPLETION OF THE FORM. I UNDERSTAND THERE WILL BE A $35.00 FEE FOR VISITS NOT CANCELLED WITHIN 24 HOURS.

PATIENT SIGNATURE ________________________________DATE __________________________

Revised HEDFG

AUTHORIZATIONS/ASSIGNMENT OF BENEFITS

I authorize the Gastroenterology Group of S.J./Endoscopy Center of S.J (hereby referenced as GGSJ/ECSJ) all my rights and benefits under any insurance contracts for payment for services rendered to me by GGSJ/ECSJ. I hereby authorize all information regarding my benefits under any insurance policy relating to any claim by GGSJ/ECSJ, to be released to GGSJ/ECSJ. I hereby authorize GGSJ/ECSJ to file insurance claims on my behalf and/or APPEAL claims for services rendered to me. I hereby authorize GGSJ/ECSJ to act in my behalf.

I understand that payment of charges incurred is due at the time of service unless other definite financial arrangements have been made prior to treatment. I hereby authorize GGSJ/ECSJ to obtain counsel and enter legal or other action on my behalf and/or in my name including the arbitration/dispute resolution process to collect such sums due, should sums not be paid within the legal prescribed time frame. In the event that GGSJ/ECSJ elects to bring a lawsuit or petition for arbitration/dispute resolution against the insurance carrier, I hereby assign my rights, title, and interest under the medical expense benefits and/or Personal Injury Policy section of any insurance policy under which I am entitled to proceed for benefits. This assignment shall allow an attorney of GGSJ/ECSJ to bring suit or submit to arbitration/dispute resolution their claim for any unpaid bills for services rendered.

I agree and acknowledge that I may receive benefits checks directly from the insurance carrier for services rendered by the provider. I agree to immediately forward said checks properly endorsed to the provider of the same. In the event this assignment if held invalid, I hereby authorize GGSJ/ECSJ to appoint an attorney to represent me directly against an insurance from which I may collect benefits. This appointment is intended on enabling the attorney to collect the funds due to GGSJ/ECSJ.

I understand that, as these services were performed for my legal dependent or myself I am financially responsible for all charges whether or not paid by insurance. I understand my insurance may not cover all fees charged by GGSJ/ECSJ. I hereby agree to be responsible for payment of all non-covered charges for payment of any remaining balance after payment by my insurance carrier. I also acknowledge and agree that interest will be added to any amount that is not paid by my insurance carrier or by me after twenty eight (28) days of the statement date. I hereby agree to an interest rate of eighteen (18%) percent.

I understand there is a **$35.00 fee for any visit not cancelled within twenty four (24) hours.**

I agree and understand there will be a service charge of **$25.00 for any returned checks**.

I agree to pay all reasonable attorney fees and collection costs in the even of default of payment of my charges.

____ ________________

Signature of patient or responsible party Date

Revised 10/09

THE GASTROENTEROLOGY GROUP/ENDOSCOPY CENTER OF S.JERSEY **HEALTH HISTORY**

602 W SHERMAN AVE, VINELAND, NJ 08360, 856-691-1400

Name ____ Today's Date __________ Birth Date ________ Age______

PROBLEM/reason for the visit/referral____

____ Date of last physical __________ by Dr. _________________________

FOR PROCEDURE: ___ Colonoscopy _____ Endoscopy/EGD ___ ERCP ____Sigmoid ____Live biopsy ____PEG/Feeding tube

SYMPTOMS: Check (x) symptoms you currently have or have had in the past year. _________ **NONE**

Gastrointestinal	**General**	**Eye, Ear, Nose, Throat**	**Men only**
__PAIN ____(grade 1-10)	__Chills ___shaking	__Bleeding gums	__Breast lump __benign
___upper ____lower	__Cold __Heat Intolerant	__Crossed eyes	__Erection difficulties
___right ___left ___mid	__Depression __Dizziness	__Difficulty swallowing	__Lump in testicles
___rectal ___anal	__Fatigue __Fainting	__Double vision	__Penis discharge __sore
___continuous/constant	__Fever __Forgetfulness	__Dry eyes __Dry mouth	__Vasectomy
___comes/goes	__Headaches	__Earache __discharge	**Women only**
__Accidents/incontinence	__Loss of sleep	__Eye pain __redness	__Abnormal pap smear
__Anal itching___swelling	__Loss of weight _____lbs	__Hay fever __Sneezing	__Abnormal periods
__Appetite poor	__Nervousness __Numb	__Hearing loss __Deaf	__Breast lump __benign
__Belching (XS) ___ Gas	__No pleasure __No energy	__Hoarseness	__Endometriosis
__Bloating ___Flatus (XS)	__Stress __Panic	__Nosebleeds	__Hysterectomy
__Bowel Changes	__Sweats __at night	__Ringing in ears	__Tubal ligation
__Constipation ___#BM/wk	__XS Thirst __Hunger XS	__Sinus problems	__Pelvic infection
__Diarrhea ___#BM/day	**Muscle/Joint/Bone**	__Smell __Taste disturbed	__Hot flashes
__Evacuation incomplete	**P**=Pain **W**=Weak **N**=Numb	__Throat tight __lump	__Nipple discharge
__Full easily/too early	__Hands __Fingers __Arms	**Vision**	__Painful intercourse
__Hemorrhoids ___surgery	__Wrists __Elbows	__Flashes __Halos	__Vaginal discharge
__Heartburn ___GERD	__Knuckles __Shoulders	__Blurred __Loss __Blind	__Menstrual pain XS
__Indigestion ___Acid	__Hips __Knees __Legs	**Cardiovascular**	______ date of last period
__Mouth Sores	__Neck __Back __Feet	__Angina __Unstable/new	______ date of last pap smear
__Nausea	**Genito-Urinary**	__Chest pain __at rest	______ date of mammogram
__Rectal Bleeding	__Blood in urine	__Heart murmur __MVP	**Pregnant NOW? (Y/N)**
__Reflux ___Regurgitation	__Frequent urination	__High blood pressure	**Skin**
__Stool ___black ___clay	__Lack of bladder control	__Irregular heart beat	__Bruise easily
___greasy ___tarry	__Pain ___burn w/urination	__Low blood pressure	__Gland/nodes enlarged
__Swallowing trouble	**Respiratory**	__Poor circulation	__Hives __Itching
__Swelling/distension	__Short of breath __at rest	__Rapid heart beat	__Moles changing
__Vomiting ___Blood	__Cough __Blood __Pus	__Swelling of ankles	__Rash __tightness
__Yellow Jaundice	__Dry __Phlegm __Wheeze	__Varicose veins	__Sore that will not heal
		__Leg cramps __at night	

CONDITIONS: Check (x) conditions you have or have had in the past. _____**NONE**

__Abused __sexually	__Colitis __Crohn's	__High cholesterol	__Phlebitis __Pneumonia
__AIDS __HIV	__Colon polyps	__Irritable bowel	__Prostate problem
__Alcoholism __Addiction	__Cirrhosis of liver	__Kidney disease __stone	__Psychiatric care
__Anemia __low iron	__Depression __PTSD	__Lactose/Milk intolerant	__Raynauds
__Anorexia __Bulimia	__Diabetes	__Liver prob __abn tests	__Rheumatic fever
__Appendicitis	__Diverticul- __osis __itis	__Measles __Mumps	__Scarlet fever
__Arthritis __Osteo __RA	__Emphysema __COPD	__Migraine headaches	__Scleroderma __Lupus
__Asthma	__Fibromyalgia	__Mini strokes/TIAs	__Stricture dilated
__Bleeding disorders	__Gallstones __removed	__Miscarriage	__Stroke __Seizure
__Blood clot __leg __lung	__Glaucoma	__Mononucleosis	__Suicide attempt __idea
__Breast lump __benign	__Goiter __thyroid nodule	__Multiple sclerosis	__Thyroid problems
__Breast problems	__Gonorrhea	__Neuropathy	__Tremor
__Bronchitis	__Gout	__Obstruction of bowel	__Tuberculosis
__Cancer of __________	__Heart attack/disease	__Osteoporosis	__Ulcer __stomach
__Cataracts __implants	__Hepatitis __A __B __C	__Pancreatitis	__duodenal __other
__Chemical dependency	__Hernia __repaired	__Pacemaker __Defibrillator	__Vaginal infections
__Chicken pox	__Herpes __Shingles	__Parkinson's __Polio	__Venereal disease

MEDICATIONS: dose (mg)/frequency (#/d) ___**NONE**		**OTC** ___**NONE**	**ALLERGIES** ___**NONE**
		__Antacids	
		__Aspirin/arthritis/pain pills	
		__Herbs	
		__Iron	
		__Laxatives	__ Latex allergy
		__Vitamins	__ Food Intolerance

FAMILY HISTORY: __Unknown (why?) __Adopted __Orphan __No contact with family

Relation	Age	Age @ death	Health problems/cause of death	Check if your **blood relatives** has any of the following Disease	Relationship to you
				☐ Arthritis, Gout	
				☐ Asthma, Hay fever	
				☐ Cancer (__colon/rectal)	
				☐ Diabetes	
				☐ Heart disease, Strokes	
				☐ High blood pressure	
				☐ Kidney Disease	
				☐ Tuberculosis	
				☐ Other	

HOSPITALIZATIONS/ SURGERIES/ SERIOUS ILLNESSES/ INJURIES/ BIOPSIES/ SPECIAL PROCEDURES/ SCOPE TESTS 'Yr	Hospital/Dr.	Illness/Procedure and Outcome/Results __ **NONE**	#____Children #____Pregnancies 'Yr Born	Sex	*if adopted Complications/Illness
			Health Habits: which/ how much		
			__ Alcohol		
			__Caffeine		
			__ Tobacco		
			__ Drugs (nonRx)		
			__ Other		
			__ **NONE OF ABOVE**		
			__ Exercise		
			__ Meditation/Prayer		

Were there any anesthesia complications with the above? Yes/No Describe ____

Has anyone in your family had a severe reaction to anesthesia? Yes/No

Have you ever had a blood transfusion? Yes/No When? __________

Occupation ____ __Homemaker __Unemployed __Veteran

__ Exposure to Hazardous Substances: (which) ____ __Heavy Lifting __Stress XS

__ Disabled: __Social Security __Temporary __Permanent Due to? Diagnosis? Why unable to work? ***Please explain***:

____

____

__Single/__Married/__Partnered/__Divorced/__Separated/__Widowed/__Birth Control method _________________/__N/A

Recent travel to_______________________. **Exposure to** __Hepatitis/__AIDS/Other__________/__Sexually active/__Inactive

Immunizations: __Hepatitis B/ __Hepatitis A/ __Flu/ __Swine flu/__Pneumonia/ __Tetanus/ __Usual childhood diseases (MMR)

Do you have a living will or advance directive? Yes __ No __

Do you have any cultural or religious customs that may impede us to provide our medical benefits to you? If so please explain

____

Are there any language, visual, or audio deficits which may hinder our ability to provide you with the best care possible?

____

Patient signature ____ **Patient Representative** ________________ **Date** ________

__ Patient incapacitated __Incompetent __ Mentally impaired __ Unable to complete form __ Required translator

Completed by: __ Self __ Spouse __ Daughter __ Son __ Family __ Guardian __ Caregiver __ Nurse __ Translator

Reviewed by: ____

The Gastroenterology Group of South Jersey
The Endoscopy Center of South Jersey

Medications/Supplements	Dosage	Number of Times per Day
*Asprin: Y/N Last dose ________ Anticoagulants: Y/N Last dose _________		

**RN will circle medication taken on day of procedure*

RN signature ___________________________ Date _______________

Patient name ___________________________ Date of Birth ________